UNIVERSITATEA BABEŞ BOLYAI CLUJ-NAPOCA
FACULTATEA DE SOCIOLOGIE ŞI ASISTENȚĂ SOCIALĂ

DOCTORAL THESIS SUMMARY

ASSISTING THE ELDERLY- MEANS AND SOLUTIONS

DOCTORAL THESIS

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Summary

Key words: the elderly, needs, resources, residential/home-based care program, organizational capital

Romania fits in the worldwide demographic picture, characterized mainly by diminishing birth rates and ageing of the population. The changes in the structure of the population, which triggers consequences especially in the work force market, the pension systems, health, social and economic systems destined to the elderly, demands the adoption of alternative services. These services mean firstly lower costs and a social efficiency superior to the existing services.

The means of delivering long-term care to the elderly is determined through the politics promoted by the government, which manages care monitored or delivered by the public administration authorities (central or local) and NGOs. A higher social efficiency and simultaneously lower financial implication attribute is offered by home care services, as an addition to residential care services. An important role held by home care services is that of supporting the family, as fundamental structure of granting support to the seniors. The results of research carried out in the above-mentioned domain (Chappell, Havens, Honorary and others (2004) indicate the critical role of informal care workers on the long-term and follow the identification of the way in which they can be sustained in their activity, by assuming care responsibilities in an efficient manner by the state.

Through its causes and effects, ageing has implication sin the social and economic plans, being part of the interest areas of international and national bodies. The policies and social assistance programs destined to the seniors deal primarily with the autonomy of this category of population, their role in family and society, the finance system of social services and the average duration of an active life.

In projecting the infrastructure of the services it is necessary to gain knowledge of the basic needs the elderly have. Due to the complexity and diversity of the needs type, concerns for the institutional development are sporadic.

The personal research consists of a comparative analysis of two care programs offered to independent seniors, semi dependent and dependent persons, respectively, institutionalized care at the house of the person for the further design of the programs, resource allocation and improvement of the offered services.

The thesis, structured in 4 chapters discusses:

- the profile of the elderly, containing physical, psychical, behavioral traits, marked by the progressive deterioration of the processes and functions of the body, causes and factors for this process;

- characteristics of the elderly quota at European and national level, their social perception and the multidimensional consequences that are determined by the ageing of the population;

- development of the social service system and protection measures addressed to all categories of persons in difficulty, including the elderly, in view of prevention, control and overcoming crisis situations;

- identification of the organizational capital of care services and of the array of the social and medical needs, economic resources, social and cultural resources that the elderly have, in view of preserving the health state and the keeping of an active life in accordance to the functional restart of every person

In the first chapter of the thesis, entitled **SENIORITY; BIO-PSYCHOSOCIAL CHARACTERISTICS; MODELS AND EXPLANATORY METHODS** the intention is to define the concepts, to present the causes, factors and results of ageing upon people. Old age is treated as a state, marked by a diminishing of the physical and intellectual capacities of the old person, which leads to the occurrence of specific needs, the necessity of evaluating them and the framing in dependence degrees (autonomous, semi dependent and dependent).

In the ageing process there are harmful transformations (senescence) and also benefic ones. Even though old age is associated to progressive diminution of the functional performances, research has proven that there is great variability in the means of deterioration of the bodily functions according to genetic legacy, biological particularities and the factors that have changed the person's life (social, psychological, environmental). (Harman, 2006). The progress of functional decline is completed up to a certain stage, followed by decompensation at the level of relevant systems. The progressive diminution of the functional reserve limits the body's capacity to answer to the action of internal and external stimuli. (Fontaine, 2008; Schroots,1996).

The diminishing of physical, psychical, functional capacities, of the competences and resources of the elder person determines the occurrence of a set of specific needs. Therefore the functional decline of the body, the deterioration of the health state (occurrence of acute affections or chronic diseases) determines *medical needs* (treatment, medical assistance); care and surveillance needs in accordance to a functional restart of everyone. The settling of semi

dependence or dependence state, which means partial or complete loss of autonomy, determines *the need for help from another person*, according to the evolution potential of each diagnosed affection.

The social field, diminished after retirement, the narrowing of the social and cultural sphere, favors the lowering of interventions between the senior and other people, shaping therefore *the need for company and social interactions*, especially in the case of lonely persons, without a family network. There are also problems tied to adapting to the new role, the result being *the need for psychological assistance, affective and emotional support needs* on behalf of the family and social group, economic problems determined by the lowering of income- *economic needs*. The lack or loss of personal housing, its deterioration, lack of utilities, of access to social and medical services, lack of transportation and lack of adapting the space to the senior's special needs determines the occurrence of the *needs determined by isolation and lack of necessary support* .The social problems (isolation and social exclusion, discrimination, ageism and loneliness) trigger *medical, socio-medical and psycho-affective needs*. In the last category, the lack of company, of spare time activities, civic implication and social utility are worth mentioning. Loneliness and social exclusion determine *the need for belonging, for relationship, for having a life filled with meaning and dignity*. Not satisfying these needs leads to the deterioration of the physical and psychical health state, the lowering of life quality.

The current legislation regulates the report between the needs of the elderly and the manner of satisfying these. Consequently, Law no. 17/2000 regarding social assistance of the seniors classifies the elderly needs according to the person's autonomy: medical needs, socio-medical needs and psycho-affective needs. These needs are evaluated in accordance to the criteria established by Decision no. 886/2000 for the approval of the National Grid of Evaluation of the elderly needs, the senior being framed in one of the three dependence degrees: autonomous, semi dependent and dependent. Each of the frames has as correspondent a certain functional restart that allows the person to accomplish some basic activities of the daily life and instrumental activities. Evaluating the autonomy degree, corroborated with the economic and social situation of the senior allows for the establishment of service types, recommended to be offered at home or in facility centers for the aged in view of satisfying the specific needs.

By comparison to the 1st chapter, where the ageing process of the individual was studied, the second chapter, entitled **THE STATE OF THE ELDERLY IN ROMANIA AND IN THE EUROPEAN UNION COUNTRIES** presents the ageing of the population.

In the last decade, the process of demographic ageing is a characteristic for most of the EU member states. According to the data provided by the Statistics Office of the European Community (CEEUROPOP 2008), this process will be accentuated until 2060 in all EU member states. Consequently, according to this estimation, based on the diminishing number of the total population in many countries, in the following decades there is an estimated growth of population aged 65 and above and a diminution of the younger population quota(0-14) and the working population (15-64). For the total of the 27 EU states there is an estimation of the quota growth of the elderly population from17,1% in 2008 to 30% in 2060, and for Romania a growth from 14,9% in 2009 to 35% in 2060 (data source: National Institute of Statistics, 2009). The accelerated speed of the ageing process in Romania is shown by the ageing index, which, correlated to the average age of the population places Romania among the most aged EU states .(The situation of the elderly, 2009)

Table 1 Romanian Population (1990 – 2007) and projections (2010-2050) (millions of persons)

	All ages	**Elder adults (55+)**	**Seniors (65+)**	**Old seniors(75+)**	**Very old seniors (80+)**
Romanian population on July 1st					
1990	23.207	4.987	2.414	0.944	0.410
1995	22.681	5.308	2.721	0.837	0.479
2000	22.435	5.281	2.986	0.999	0.401
2005	21.624	5.407	3.191	1.194	0.529
2007	21.538	5.545	3.200	1.277	0.587
EUROPOP projections 2008					
2010	21.3		3.2		0.6
2020	20.8		3.6		0.9
2030	20.0		4.1		1.0
2040	19.2		4.9		1.4
2050	18.1		5.6		1.7
2060	16.9		5.9		2.2

Source of data: I.N.S., 2009

This evolution is explained through the action of the demographic factors (fertility, mortality and migration), which have a major impact in the population ageing phenomenon. In Romania there is a major influence of the first two factors, the values registered by migration being less significant. Fertility and mortality registers a passage from the traditional

regimes characterized by evolution, to the modern regimes, characterized by a diminution. In the action of these two factors, fertility represents the active factor, with decisive action, and mortality produces effects in time, with two directions of influence: population rejuvenation effects (by lowering of the infantile mortality) and population ageing (by growth of the old population). The growth of the elderly quota is due both to the large numbers that have survived infantile and juvenile mortality, reaching the third age group, and to the growth of life expectance in all ages.

Due to the fact that the active population supports the inactive population, we consider important to mention the evolution of the dependence rapport for the elder. The values of this indicator show a growth from 21% in 2007, to 26% in 2020 and to 65% in 2060. In Romania a growth of the dependence rapport is estimated from 15,5 % to 24,6% (source of data: The situation of the elderly, 2009).In 2009, the proportion between the medium number of pensioners with state supported social insurance and the medium number of the remunerated was 9 to 10. The same level of proportion was registered in 6 of the country's counties (Alba, Bistrița – Năsăud, Covasna, Galați, Iaşi and Tulcea) and it was inferior in 8 counties, the lowest proportion -5 to 10- being registered in Bucharest. In the other 28 counties the proportion was above country average, the highest value being reached in Giurgiu and Teleorman (18 to 10). (data source. Number of pensioners and the average monthly pension, 2009)

Another significant indicator for the topic is the parental support index. This indicator renders the number of the elder persons in the 80+ group to the number of persons in the 55-64 year group. The highest values are found in South-Muntenia, South-West Oltenia and Bucuresti-Ilfov. The North-West region registers the lowest values-22%. (Data source: The situation of the elderly in Romania, 2009.)

From a socio-economic point of view, the ageing of the population means an increase of pension expenses in the European Union. For supporting this type of expenses, some state members have adopted reforms of the pension system that mean: increasing the retirement age, restricting access to early retirement, modification of pension indexation, sharpening eligibility conditions for public pensions and offering alternative in the private system. The financial and economic crisis affects mainly the redistributive pension systems, which are affected by the fiscal pressure exercised upon contributions and financing. (Report regarding the ageing of the population, 2009). In Romania, the social care granted to the elderly as pension represents the most representative budgetary chapter in the social protection system. (Risks and social inequities in Romania, 2009). Nonetheless, unlike the average number of the

seniors, the evolution of the pensioners number registers a decreasing tendency, in 2003 being 6.306.300 persons (6.274.150 having social insurance pensions), and in 2009 being 5.688.563 persons (5.675.629 with social insurance pensions.) data source. Number of pensioners and the average monthly pension, 2009).

While for the salary increases one has used inflation indicators, work productivity indicators, economic growth and other indicators, for the pension indexation one took into account only the inflation index. This led to major discrepancies between the level of the average salary and an average pension, starting in the 90s. Consequently, the proportion between the average pension and the average salary shows a decrease of the net value from 51.1% in October 1990 to 45,8% in December 2008 (data source: Number of pensioners and the average monthly pension, 2009). The continual price increases for the main foods and services, associated with the pension levels determined a lower living standard of this category of the population compared to other age groups. The diminution of the buying power of the pensions shaped a consumer behavior oriented mainly towards paying house expenses and current services and giving up buying foods and medicine. In order to satisfy the basic needs and ensure the necessary services for the maintenance or recovery of the health state it is necessary to apply exceptional measures.

Table 2 Structure of the expenses in pensioners' households

Expenses	**2005**	**2008**
Total	889,09	1504,48
Financial expenses	75,5	79,5
- food	23,9	23,5
- non-food	21,3	23,2
- payment of utilities	17,2	17,0
- investment expenses	1,1	2,0
Production expenses	2,7	2,3
-taxes	5,2	7,0
-equivalent value of agricultural products from own resources	24,5	20,5

Data source: Coordinates of the living standard in 2009

From the point of view of the living standard, the indicators show the fact that seniors' revenues only allow them to satisfy their needs ala lower scale, with priority over purchasing foods and medicine. Secondly, there is utilities payment, some households being behind with such payments. Therefore, in 2009, 30.3% of the total such households didn't have the possibility to pay in due time the services related to home maintenance. Of the

indebted households, 40.8% were located in the urban areas and 29% in the rural ones (Living conditions of the Romanian population, 2009).

After covering the expenses determined by household and living conditions (for household production and tax payment), those determined by transport to and from work, by health condition, the level of revenues a family has in order to cater for their needs is extremely low. In the first category of expenses, services linked to household have the highest proportion for all categories of analyzed households, representing over 50% from the total expenses in the case of unemployed and pensioners' households in 2009. Lastly, the revenues are allocated to the other service category, connected, for example, to the use of the spare time, culture, personal care, insurance etc., for which reason this category is quite insignificant (Living conditions of the Romanian population, 2009).

The image and representations of the elderly over the socio-economic situation in which they are shows that 85% of the total interviewed households can barely deal with the current life expenses. Out of these households 56.8% are managed by women or persons over 65, and over half of the urban households estimate expenses to reach 2000 lei. Households led by women or elder people, as well as agricultures estimate current expenses about 500 lei (Situation of the elderly in Romania apud. Generation Poll and Gen. 2005). The socio-economic situation influences the health state as well. Therefore, in 2008, the health state of the Romanian population is in a critical state, determined by: poverty (lack of financial resources, insufficient food, bad living conditions, lack of access to elementary hygiene conditions), social disorganization (giving up concern towards own health, unhealthy lifestyles, shortage of culture and sanitary education), insufficient prevention services and ambulatory treatment. Among the social groups with limited access to the medical services are also the elderly.

The current system of medical and social assistance for the elderly distinguishes a series of essential aspects that need to be considered: old age is accompanied by loneliness, isolation, high risk of presenting diseases, dependence-generating ones. (H.G.R. nr.541/09.06.2005)

Due to the special needs there are two types of support: social services and medical services. In these conditions a social unitary policy was initiated and developed, in order to support the elderly in their own homes or, if possible, to give the necessary support for continuing life in a care institution with social or socio-medical assistance.

The reference of societies to the problematic of the elderly is different according to the structure, economic and cultural level of each society. From a social and cultural

perspective, the manner of approaching the ageing phenomenon is determined by the mentalities and social models of reporting to old age. The social attitude towards the elderly, more like compassion than respect, reflects the cleavage between society and the tradition that led to it. By determining the means of perception of the people over the elderly one can measure the report interest of society to their problems (Popa, 2000).

The report of the international inquiry Policy Acceptance illustrates the way in which EU states regard ageing populations and the role of the seniors in society. Comparative to the demographic ageing which is negatively assessed, the elderly are considered useful to society, they guarantee the keeping of traditional values (Romania is ranked on the 2nd position- 88.3% after Poland (89,3%), being an important resource to society. In this sense, society must take into account the elderly's rights (95.3% of the Romanian respondents) and their problems (94.9% in the case of the Romanian respondents). The negative image of the elderly in society, determined by the economic aspect (budgetary resources allocated to the seniors), by the evolution of society (seniors are an obstacle in implementing change) and the social role (burden to society), is shared by few respondents in the EU countries (percentages are below 20) (Situation of the elderly in Romania apud. Dobrity et al., 2005).

The ageing of the population, through its demographic, economic, social and medical characteristics it represents, means reconsidering the social and health policies by adapting them to the specific needs of the seniors and developing some social and medical service systems, adequate to the needs if resources are reduced.

The fact that many families already have problems in covering the range of needs makes their vulnerability to the risk of losing or diminishing incomes and the diminution of the buying power to be much bigger than in the conditions of a higher living standard.

Chapter III, **SOCIAL SERVICES DELIVERED TO THE ELDERLY,** analyses the means of caring for the seniors. The prevalent values in Romanian families, centered on the attachment towards family and the conservative attitude, according to which children have the duty of taking care of their parents, providing financial and locative support in the semi dependence and dependence situation, shows the manner of implication of the family members in care activities. These activities are sometimes performed instead of other social of family activities. The moral duty thus rendered shapes the role of public support in the family welfare. Moreover, the traditional attitude regarding the support and care provisions to disadvantages categories grants the family network a fundamental role in problem solving, the support of the state being mainly financial (Pescaru-Urse, 2009). The study of Generation and Gen 2007 shows people's attitudes concerning society's role in fostering for the elderly. In the

case of attending to the seniors in their own household, this activity is firstly reserved to the family (45, 4% of the respondents), unlike the provision of financial support to the seniors who live below substance level, where the main role of financial support belongs to the state (51,4% of the interviewed persons).

Another factor that influences the public support is represented by the growth of the occupation rate in the socio-demographic structure of the countries, especially the developed ones. In these conditions, the role of the state in ensuring care and protection to the dependent persons is growing. Taking the family responsibility to care for these persons has a negative effect both at macro social level (through reduced economic contribution of the family members who take over this task) and at micro-social level (staying inside the household can be the result of a structural, economic restriction). Especially in the southern countries of Europe, the extended family has an important role in carrying out domestic tasks.

The traditional character of the Romanian state, the adults' duty to care and support the parents is mentioned as obligatory in the current legislation, the state entering the field only secondarily, by completion or replacement of the family in completing the duties. The intervention of the state consists in granting benefits of social assistance and social services to the elderly who are in a vulnerable situation (insufficient income to own a house, to have decent living standards and a safe life environment, reduced functional capacity that determines the need for help on behalf of others, other emergency or necessity situations) (Law no. 292/2011).

In Romania, the assistance and social protection system only comes in addition or complementary to the health insurance system and is regulated by special legislation. The general framework of organizing, functioning and financing of the system is regulated by Law 292 from December 20th 2011. On the grounds of this law, the emphasis is on creating equal opportunities to all people and secondly on providing a unitary block of correlated measures, classified in two categories: the social assistance benefits system and the social service system.

The provision of the social assistance benefits to the seniors focuses on prevention and fighting against poverty, the social exclusion risk and crisis situation intervention. In this sense, the elderly with insufficient funds can benefit from social help from the state budget (Law no. 416/2001, which stipulates the concession of financial support, household heating relief, foods, medicine and medical devices etc-established by City Councils' decisions), social canteen foster supported by local budgets (Law no. 208/1997, art.2, lit.d and e), facilities for urban and intercity transportation (Law no, 147/2000), balnear treatment tickets

(Law no. 215/2001, Law no 294/2011), compensations, gratuities and facilities for the elderly having a handicap or disability degree (Law no 448/2006, republished with the consequent modifications). Unlike prior legislation in the field of assistance and social protection of the elderly, Law no. 292/2011 stipulates the granting of care compensations, gratuities or contributions for ensuring the quality of the social services, destined to cover the costs of food in social canteens, in residential care centers, as well as to supporting some nutritional supplements and allowances for crisis situations, or avoiding institutionalization (art. 94, alin. 2, lit. b,c and e). Likewise, the facilities that can be granted to the seniors do not have a restrictive character, but rather it is the City Council that identifies the social assistance benefits to be given to the elderly.

The European tendency of externalizing social services from the state responsibility can be found in the specification of the responsibilities for development, administration and provision of these types of services, in the text of Law no. 292/2011. The role of the state is materialized in the elaboration of public policies, programs, national strategies in the field and the monitoring of these policies. The implication of the nongovernmental sector (natural or legal persons constituted in view of legislation or cult institutions) can be seen in the organization, management and provision of social services, where a complementarily between the private and public sectors can be forged(authorities of the local public administration). The territorial organization of the social services delivered in the public or private field contains local interest services (one must obey the territorial autonomy of villages, town, cities, capital cities) and county social services (addressed to the beneficiaries located in the territorial surface of a county). Through partnership contracts (approved by decisions of the City Councils); the array of providing social services can be expanded to serve several counties. The emphasis in delivering social services is on respecting the quality standards and the general rules of minimum staff provision that are at the basis of establishing the cost standards (H.G.R. no. 23/2010).

The purveyors of social services can be public entities (structures trained from the public central or local administrations as well as executive authorities; sanitary units, school units and other public institutions that develop, at a community level, integrated social services) or private (NGOs, cults, legally authorized persons, economic operators and subsidiaries or branches of associations and international foundations in accordance to current legislation (Law no. 292/2011 art.37). In delivering the social services, this legislation mentions an eliminatory condition that is the credibility of the purveyors.

The social service system is offered to the elderly in residential regime (temporary care centers, full-time care centers-nursing homes for the seniors-protected households, service centers) (Law no.292/2011, art. 101, alin. 2, lit. a-c) or without accommodation (day-care centers, clubs for seniors, social canteens, mobile foster services, social ambulance) (Law no. 17/2000, art.7, alin.1, lit.a-c; Law no.292/2011), according to the socio-economic situation, health condition, level of education and social environment in which the person is. These social services are classified in „assistance and support services for covering the basic needs of the person, personal care services, recovery/rehabilitation services, insertion/social reinsertion services, etc. (Law no.292/2011, art.30, alin.1). This article is not restrictive; there is the possibility of diversifying the service types, adequate to the needs of the elderly.

An important aspect in providing the services is following the stages: initial evaluation, elaboration of the intervention plan; complex evaluation; elaboration of the individualized plan for assistance and care; implementation of the measures in the intervention plan; monitoring and evaluation in service delivery. (Law no. 292/2011). In taking these steps, the beneficiary has an active role; including choosing the service provider that can partially or totally cover the identified needs. The text of the legislation mentions specifically the dependent elderly, who benefit from personal care services delivered at home or in residential centers (when it is impossible to keep them at home) as well as long-term care.

The category of the seniors that can benefit from social services is mentioned in Law no. 17/2000. According to the provisions in art.3, lit. a-e, seniors can benefit from the social services if they are in one of the following situations: they do not have a family or legally entitled persons; they have no accommodation of financial possibility to cater for living conditions; they don't have personal revenues or they are insufficient to cover for the necessary care; they cannot manage themselves or need specialized care; they cannot cover for the socio-economic needs because of affections or the physical and psychical state.

Chapter IV, **ASSESSMENT OF THE SOCIAL PROGRAMS DESTINED TO THE ELDERLY IN BISTRIȚA-NĂSĂUD** represents the personal research and describes the care modalities of the elderly in Bistrița–Năsăud, analyzing at the same time their efficiency from two perspectives: of the institution and the beneficiaries. Throughout the research, the intention was to identify and observe the evolution of the management capital (Home Assistance Compartment for the elderly and Nursing Home for the elderly) and beneficiaries' capital (economic, cultural, and social) throughout January 1st 2006 and

December 31st 2011. The research included the beneficiaries of the care services and the employed staff. The beneficiaries' lot included older people who reached the legal retirement age and received long-term care in an institutionalized form or at home through the „Nursing Home for the Elderly" Service. We selected the elderly from the records of the institutions as follows: framing in the three dependence degrees; time span for service delivery-a minimum of 4 months; similar services that are given at home and inside the institution; stability level of health state.

We excluded the persons with chronic diseases that needed long-term treatment, comparative to those delivered in socio-economic units. Another category of seniors was left aside-the unstable persons, whose health state deteriorates rapidly and requires transfers in socio-medical institutions (people diagnosed with senile dementia, Alzheimer, malignant tumors-advanced stage). In the case of home care people, the sample excluded the persons who get care from other centers (medical care, monitoring, spare time), being considered extra costs of the elderly who do not make the object of this research.

The main methods used in the research are: quantitative analysis of numerical documents, official and unofficial, with public character, the questionnaire, statistic analysis, and semi structured interview and case study. The questionnaire (37 questions) was applied to the beneficiaries of care services in an oral form, by direct discussion. The economic capital was evaluated (household, revenues, lands), along with the cultural capital (studies, profession prior to retirement) and the social capital (family and social network). The nature of the data is valid, the research report containing figures, tables, graphs and comments. The questionnaire applied to the care staff consists of 3 items referring to the quantity and quality of the material resourced reported to the delivery of care services in optimum conditions, as well as to the modalities of improving the activity under the aspect of the organizational capital. Through the semi structured interview, the intention was to identify the resources of the elderly, the factors that influence the choice over a care program (institutional or home-delivered), and the satisfaction of the beneficiaries in proportion to the services delivered and the results of the services. The multiple case studies pointed out the characteristics the persons and the situations in which long-term services are delivered. The paper presents 10 case studies, 5 studies for each care program.

The results of the current study render the following aspects:

1. The institutional framework by organization means and the resources it has (human, material and financial) responds to the care needs of the elderly fitting the three dependence categories. Ensuring the permanence

of the services, the surveillance and daily medical care, the medicine and sanitary material delivery is materialized in stabilizing the health state and diminishing the number of hospitalizations. Likewise, the residential environment by material resources and equipment ensures that the elderly benefit from a safe, stable environment and decent living conditions, covering the array of the seniors' social needs.

2. Formal care services by the nature they present (limited delivery time) are addressed to persons with good health state, reduced functional limitations or to those who benefit from informal caretakers' services. These formal home services focus mainly on satisfying the array of social and medical needs of the beneficiaries.

Considering the dependence and social reinsertion degree of the elderly who require long-term care, we carried out an analysis of the care needs and the resources of this persons' category, in order to identify the situations in which long-term care can be delivered either at home or in residential institutions.

A. Care services delivered at the elderly homes

The persons registered in 1st degree dependence do not have or have partial bodily or mental self-control. The damaged physical or psychical health state, the diminished or lack of functional capacity determines mainly biological needs, medical and secondly psycho-affective and social needs. In order to fulfill these needs, the delivered services are centered on the continuous surveillance and personal care and on providing help in covering the basic instrumental daily chores. Secondly, the services account for recovery and socializing activities. To ensure continuity of surveillance and home-based care, the senior requires a mobilization of the social and economic capital. The care activities means continuous presence of the formal and informal caretakers. The involvement of the social network imposes because, through the formal care system, home-based care can be provided for a limited number of hours (8 hours), which means that the rest of activities must be completed by informal caretakers.

Taking responsibility for the care of an elder implies participating in strenuous activities that take time, effort and giving up other tasks. The economic capital represented mainly by the household, arrangements and facilities determined by the health state of the person is an important factor in ensuring life quality to the dependent elderly. Current expenses are completed by sums of money allocated for the purchase of food, devices, treatments, medication, consultations made by physicians or specialists.

The traits of persons registered in 2nd dependence degree (semi dependents) imply the conservation of mental autonomy and partially of locomotors autonomy. Due to the keeping of the mental independence, this category of persons pays importance both to the affections they suffer from and to other aspects represented by revenue level and interpersonal relations. Referring to the first aspect, the altered health state and the partially reduced functional capacity determines reduced biological needs, medical needs, psycho-affective ones and social needs. The level of care is modified, with emphasis on the help with carrying out instrumental activities, while personal care activities are diminished. The continuous presence of the caretakers is not mandatory, as there is an appreciatively equal proportion between the number of hours destined to care taking through the home-based system and those provided by informal caretakers. In some cases (developed network of home-based care), services can be provided exclusively by the home-based care network. The economic capital, represented by household, revenues, facilities, is sometimes insufficient for the coverage of medical devices, arrangement and extra equipment, determined by the adoption of a certain diet, permanent medication, visits to the doctor, all representing additional costs. The presence of the family and social network becomes a determinant factor in the semi dependent persons' state. The quality of these relations, the time spent with the family members and the importance shows to the senior determines the affective, emotional and sentimental experience, having repercussions upon the health state.

The persons registered in 3rd dependence degree (autonomous persons) presents a health state marked by chronic affections, but who are not invalidated, and bearing reduces or no repercussion upon the functional capacity. An essential aspect is represented by the change of the life rhythm, the schedule, the revenues and the roles that determine a positive or negative report to the status of being an old person. The needs of this category of people focuses more on the social aspect, the psychological one, as the seniors can carry out by themselves the daily tasks or they require only little help in these instrumental activities. This type of activities can be taken by the home-based care system. The social sphere and the relationship represent key aspects, with the family occupying the first position and in subsidiary being the social network (friends, neighbors, colleagues). These relations can be affected by the revenue level, after paying the bills for utilities, the purchase of food and medication, while the amount of money destined to cultural activities or visits is sometimes reduced.

Therefore, people who can be home-care assisted show the following traits: reduced degree of autonomy loss (3rd degree-autonomous persons), minimum economic

capital(accommodation, facilities, revenue) and minimum social capital (informal caretakers coming from the family or social medium); total or partial loss of autonomy (1st degree-dependent persons), extended economic capital (accommodation, facilities, medical devices, medical treatments, medication, arrangements and facilities specific to the loss of autonomy characterized by a minimum or missing functional capacity), well represented social capital rendered by the social and family network.

B. Care delivered in residential institutions (Nursing Homes for the elderly)

The delivery of services to the elderly in residential regime is accomplished similar to home-based care, in accordance to the dependence degree and the needs of the person. According to the dependence degree of the person, they are distributes in specific compartments within the Nursing Home (for autonomous, semi dependent and dependent persons) ad will receive the necessary help on behalf of the formal staff. Referring to the social capital we can mention that it is reduced or missing, the family relations are not characterized by the specific cohesion, based on trust, help, mutual support, respect, duty. Social relations with friends, neighbors and colleagues, are interrupted for 82% of the institutionalized persons (The Nursing Home's visit records) after their hospitalization.

The relations of the institutionalized persons are accomplished firstly with the institution's staff, during the current activities. Due to the reduced social capital there are sadness feelings, frustration, loneliness, which negatively affect life quality, influencing the health state. The economic capital for the institutionalized is represented by the personal financial revenue. The institution provides food, clothing, materials and equipment necessary to a decent living standard, as well as medication, medical treatment and devices, the only financial contribution being the monthly maintenance fee. This contribution represents up to 60% of the senior's revenue (Law no. 17/2000), the rest of 40% being available to the person. The resident with no income are financially sustained by the persons entrusted with their support (1st degree relatives, grandsons, granddaughters, persons who have signed a contract with the elder person) or the location Mayor Hall. Institutionalized persons benefit from the material basis of the center, personalizing his/her space with personal belongings. As this space is limited, there is no need for extra expenses to go beyond the personal budget. Likewise, the institution must cater for diverse nourishment, corresponding to the age and affection, served according to a set schedule, permanent supervision, medical assistance, determines the growth of the life quality of these persons.

Considering the above mentioned analysis criteria, persons being taken care of in a residential facility present the following characteristics: framing in one of the three degrees of

dependence (autonomous, semi dependent or dependent), absence or presence of economic capital (household, revenues) and social capital. The protection function of the elderly is accomplished in this case by taking over, partially or totally, of the care responsibility by the state, the needs of the beneficiaries being completely covered by the state through accommodation, food, and clothing, in the conditions of either existence or lack of the elder's social and economic capital.

The elderly who receive long-term treatment and care through the two assistance modalities (home-based or in residential centers) are put in a dependence degree and requires full/partial help in carrying out the basic daily activities and/or the instrumental activities.

In order to benefit from home-based care, the elderly must have a minimum economic capital (accommodation, assets, equipment, revenues to pay for the maintenance of the household, of oneself-food, clothing, medication-paying the contribution for the delivered care) and social capital(family or social network). The importance and implication of the social network in the care activities of the person increases along with the dependence degree, being indispensable in the case of 1st degree dependence.

Conclusions

The problematic of ageing imposes a differentiation between the two processes: ageing of the person and ageing of the population. Firstly, ageing is considered a normal degenerative process, a physiological state with own legities and characteristics, which occurs along with time. Due to the functional decline, the limitation of the reserve capacity, the diminution of the coordination capacity, of homeostasis and control mechanisms over the organs' activity, the immunity of the old person decreases, the vulnerability to the action of internal and external factors increases and one becomes more and more prone to diseases. In the case where affections are not treated in due time and in a manner, functional deterioration occurs, which calls for medical assistance. According to the family situation of the elderly, the medical problems can further trigger social issues.

The consequences of the demographic process of ageing population, associated to the decrease of birth rate in the context of actual policies can be analyzed in view of the lack of balance in the financial plan (increasing the public expenses regarding pensions, health,

infrastructure, households), familial(between professional and family life) and socio-economic.

From a financial perspective, a primary aspect consists of the increasing tendency of the dependence report and the parental support index; the cost of the ageing population means raising the public expenses by at least 7 % in GDP in 9 of the member states, characterized by modification of the reform flow and the improvement of modeling techniques. Romania is part of this group. The sustainability of this category of expenses involves both the evaluation of the pension total and of the other categories of expenses generated by the ageing population phenomenon (health, long-term care, offering the elderly other services). It is estimated that there will be an expenses increase determined by caring for the elderly health with 0.5% out of GDP by 2060, both regarding treatment destined to handling the seniors' affections and the investments in technology and recent diagnosis methods. Moreover, one estimates a public expenses increase by 1¼% from GDP until 2060 in the domain of long-term care, due to the need of increasing formal assistance. Informal support, provided especially by family will be reduced due to women's participation in the labor market and the growth of the geographic mobility. (Report concerning the ageing of population, 2009).

A negative effect can be found in the case of the aging population. Reduced incomes, decrease of the buying power, price increase expands the seniors' vulnerability and amplifies the risk of poverty and social exclusion of this group of persons. The degrading of living conditions is also influences by the lack of savings in most seniors' household (wrecked economies in crisis conditions: death of spouse, severe affections, house issues) (Risks and social inequities in Romania, 2009; Niculescu-Aron,Voineagu, Mihăescu, Căplescu, 2010).

At family level, the pressure exercised upon family regarding child care, persons with disabilities and the elderly, determines consequences on the labor market (by reducing women participation), on the financial level (cutting down incomes), demographically (decrease of birth rate due to costs caused by upbringing of children). The diminution or loss of income amplifies the risk of poverty and social exclusion.

On a socio-economic level, the increase of the total number of pensioners, the deterioration of the dependence report between the old population and the working one, the increase of the sudden mortality rate and the pressure degree upon family also lead to an increase of the necessary expenses to programs destined to the seniors (transfers and specific public sector services). The difficulties registers in the case of the social insurance system resides in reducing the number of tax payers to the pension fund comparative to an increase of the pensioners' number and the pension giving period. Other difficulties consist in the social

reinsertion of the seniors due to the small number of jobs suitable for these categories and the lack of structures that can absorb them. This requires a continuous adaptation of the social protection system infrastructure.

In ensuring the protection of the elderly two major directions can be identified: securing the quality of the living conditions and adapting the support system of the seniors. While developed countries aim at investing in the human resource, social protection, safety of the individual, developing countries emphasize the indicators system that characterizes the poverty degree in configuring the economic growth policies meant to improve the population's living standards. In this context, the ageing of the population generates two positions. The first, of orientation, is based on the belief that the consequences of the ageing process, unlike other demographic risks, can be anticipated and solutions can be identified to adapt to the new situation. The second position, of pessimist nature, regarding the negative effects of the ageing process shows three aspects: the destiny of the modern society, the effects felt on the labor market and the pension systems, health insurance policies and in the socio-medical care domain. The increase of the elderly number also means the growth of the need for medical and social services materialized in extra costs to cater for the protection and assistance of this category of persons (Klein 1999, Nechita 2008).

Regarding the first aspect, the risk induced by the ageing process hints at the progress capacity of society, the value systems, considering that the decrease of physical and intellectual qualities of the seniors will also occur at society's level. The diminution of the seniors' capacities triggers consequences on the labor market because it doesn't allow these people to work with new technologies, which can be seen as an obstacle in the economic progress. By comparison to the elderly, the youth show better training, and competences that are adequate to modern society. In the protection care systems to the elderly, scenarios generally focus on ensuring the financial resources destined to the old from a budget constituted from the contribution system of social insurance and the capacity to assimilate the increasing number of seniors in protection systems.

The healthy life expectancy and the health state depend primarily on the organization and financing of the health services and long-term care. If these have a functional structure and sufficient resources, the two indicators above-mentioned shows high percentages. In Romania the access of the elderly to medical services is limited due to the factors that depend both on the system and the economic, sociodemographic and cultural traits of the seniors. In the first category, one must mention: " the degree of seizing the population in the insurance system, covering services through basic package (the health basket), financial factors (co-

payment), geographic factors (distance), organizational factors (functioning schedule, waiting list), absence/adequate information" (Risks and social inequities in Romania, 2009, p. 134).

The personal characteristics of the elderly that represent risk factors of the health state are illustrated by: age, education, income, medical needs, belonging to a discriminated group. The social risk factors and the dependence degree of the aged person influence his/her option towards a certain care program: home-based or residential. Community services delivered to the elderly at home aim at keeping the persons registered in a dependence degree at home. In this sense, the services are destined to accomplishing the basic and instrumental activities, to preventing or limiting the functional autonomy degrading, to preserving the health state and ensuring a decent and dignified life (Order no.246/2006). Unlike these services, the community services delivered to the seniors in residential regime can be exceptionally offered to those who have the conditions stipulated in the Law no. 17/2000 and is classified in: social services (housekeeping; juridical and administrative counseling; preventing social exclusion and social reintegration in respect to the psycho affective capacity); sociomedical services (keeping or readapting physical or intellectual capacities, ensuring occupational therapy, support in handling with bodily hygiene) and medical services (consultations and treatments at the doctor's office, in specialized medical institutions, nursing and care services, medication delivery, handling medical devices, consultations and dental care).

The residential care delivery is not conditioned by the economic and social capital of the elderly, these gaining assistance and social protection in report to the sociomedical situation and the economic resources they own.

The importance of the current doctoral thesis consists in distinguishing the characteristics of caring for the elderly and the role of the formal services under the aspect of satisfying these persons' needs, and in the conditions of decreasing financial resources. This service granted to the elderly in two modalities (home-based and institutional) focuses on the care needs of the beneficiaries and utilizes the resources (economic, social, and cultural) they have. Care services delivered in the institutional environment aim at offering suitable living conditions to the seniors. The purpose of home-based care by formal services is to complete the informal/family care, allowing for the maintenance of the person in his/her common lifestyle. This research approach underlines the complementarily of the two types of care systems in view of satisfying in an effective manner the needs' array of the beneficiary.

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